7510 E. Independence Blvd, Suite 105Charlotte, North Carolina 28227
Telephone: (704) 531-2467 Fax: (704) 531-4414

Registration Form

______ **Date** ______ Last Name: ______ First ______ Middle ______ Date of Birth ______ Age

______ Address ______ City ______ County ______ State ______ Zip Code

______ Cell Phone ______ Home Phone ______ Social Security # **(Optional)**

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Race (Choose all that Apply): ☐ Black Or African American ☐ Asian ☐ White
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander

Gender at Birth: ☐ Male ☐ Female ☐ Transgender-MTF ☐ Transgender-FTM

Current Gender: ☐ Male ☐ Female ☐ Transgender-MTF ☐ Transgender-FTM

Females Only: Are you Pregnant? ☐Yes ☐No if **yes, are you receiving prenatal care?** ☐Yes ☐No

Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐ Partnered ☐Widow

Have you ever been tested for HIV, the virus that causes AIDS? ☐Yes ☐No

Results: ☐Negative ☐Positive ☐Unknown

Have you ever had a sexually transmitted disease (STD)? ☐Yes ☐No **did you receive treatment?** ☐Yes ☐No

If yes, please check which one and when (month and year):

☐Syphilis (_____) ☐ Gonorrhea (_____) ☐Chlamydia (_____) ☐NGU (___ ___) ☐MPC (_____) ☐Trichomonas (_____)

☐PID (_____) ☐ Herpes (___ __) ☐ Hep B (_____) ☐ Genital Warts (_____) ☐Other (_______)

Please check all the boxes below that apply to you within the past 12 Months:

☐Sex with Man
☐Sex with Women
☐Sex with a man who had sex with a man
☐Used injection drugs
☐Shared drug injection equipment

☐Sex with an injection drug user
☐Sex with HIV+ Person
☐Sex in exchange for drugs or money
☐Sex while intoxicated and/or High on drugs
☐Sex with an Anonymous partner

☐Health Care exposure
☐Forced to have sex against your will
☐Child of HIV+ mother
☐No known risk

In the last three months:

How many male sexual partners have you had? ____ **How many female sexual partners have you had?** ____

What type of sex have you had? ☐Anal (Give) ☐Anal (Receiver) ☐Vaginal ☐Oral

______ ***Emergency Contact*** ______ ***Emergency Contact Phone Number***

For Office Use Only

Lot number ____________________ *Sample Date* ___________________ *Pretest Counselor*_________________ ***Test Type:*** ☐*Conventional* ☐*Rapid*

Specimen Type☐*Blood-finger stick* ☐*Blood-venipuncture* ☐*Oral Swab* *If rapid reactive, did client provide confirmatory sample?* ☐*Yes* ☐*No*

Client declined confirmatory test ☐ *Did not return/could not locate*☐ *Referred to another agency*☐ *Other*____________________________________

Consent to Program & Test for HIV Infection

Your identity in this program will be treated as confidential. The information provided, including laboratory or any other data, may be published for scientific purposes or reported for statistical purposes to local health departments, Centers for Disease Control and Prevention (CDC), or relevant public health entities but will not give your name or include any identifiable references to you except where disclosure is otherwise required by law or a court of competent jurisdiction. These records will be kept private in so far as permitted by law.

I ____,
Print Name First Middle Last

I have read and understand this consent statement, and I volunteer to participate in this program. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this program. I further understand that nothing in this consent statement is intended to replace any applicable Federal, state, or local laws.

Acknowledge that the nature of the tests to be performed and their accuracy have been explained to me, along with both the risks and benefits of having the test(s) performed. If I choose not to be tested for HIV infection, I understand that services will still be provided.

I have read this consent and have been given the opportunity to ask questions. My questions regarding HIV testing have been answered to my satisfaction.

☐ **Yes, I Do** agree to be tested confidentially for HIV infection and understand that my test results will be recorded in my medical record. Information collected may be used to evaluate the HIV Counseling, Testing, and Referral program. I understand all program evaluations will maintain my confidentiality.

☐ **No, I Do Not** Agree to be tested confidentially at this time for HIV infection.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Witness	Date

Confidentiality of Participant and Receipt of Agency Privacy Practices

By signing below, I acknowledge that I have been given access to a copy of Carolinas Care Partnership's Notice of Privacy Practices (HIPPA) and been offered a brochure about HIV testing.

The confidentiality of participant records maintained by this program is protected by both Federal and Sate Laws and regulations. Generally, the program may not disclose any information which identifies a participant to outside persons or agencies, nor may the results of any medical tests (positive or negative) be disclosed unless:

- The participant consents in writing; or
- The disclosure is required by law to a DIS representative in the event of a positive HIV or other STD test for purposes of contact tracing or partner notification.

______________________________	______________________________
Signature	Date